PROGRAM CONTROLS AND ADMINISTRATIVE SERVICES

MEDICAID QUALITY CONTROL

The HealthChoice staff is responsible for the review, monitoring and quality assessment of all services provided to recipients enrolled in HealthChoice through the Quality Assurance Monitoring Program. Currently, major responsibilities include the administration of the external quality review organization contract, medical record reviews and clinically focused studies, analysis of MCO and enrollee-reported data like complaint calls and claims payments, development of the MCO performance reporting mechanisms, development of recipient and provider satisfaction surveys, and EPSDT performance improvement audits of certified providers.

PREAUTHORIZATION

Preauthorization of certain services provides an effective means for utilization control and cost containment in the Medicaid fee-for-service program. The following services require that the Medicaid provider obtain authorization before rendering the service: non-emergency inpatient hospital services, designated organ transplants, cosmetic or obesity surgery, private duty nursing services, medical supplies which cost more than $300 or which must meet certain medical necessity criteria, and prescriptions over $400 or for more than the Program's designated maximum limits. In addition, certain dental, podiatry, vision, oxygen, home health services, audiology, durable medical equipment and supplies services must be preauthorized.

SURVEILLANCE AND UTILIZATION REVIEW SUBSYSTEM (SURS)

The Surveillance and Utilization Review Subsystem (SURS) Control Unit is responsible for the development and maintenance of the SURS Control File. Its purpose is to produce reports for use by the Medicaid staff and other agencies, federal and State, to provide comprehensive profiles of the utilization of services by providers and recipients of the Medicaid Program. These reports are used to assist in the detection of Program fraud and abuse, monitor quality of service and provide a function for the development of program policy. PC-SURS is capable of providing surveillance and under/over utilization data, as well as identifying quality of care issues in a fee-for-service and managed care environment concurrently.

The SURS Control Unit is responsible for interpreting and assuring continued compliance with the federal guidelines for the State of Maryland. MMIS certification is dependent upon continued certification of all sub-systems, of which SURS is one.

FRAUD AND ABUSE INVESTIGATIONS

The Program investigates allegations of recipient Medicaid fraud in order to seek criminal prosecutions for violations of law and to maximize the recovery of monies spent for Medical Assistance benefits for which there was no entitlement. Recipient fraud may result from the failure to report income or resources, the use of Medicaid cards by ineligible persons, or the forging or alteration of prescriptions. Referrals of

potential fraud come from providers, local departments of social services, police and citizens.

The Program investigates cases of possible abuse by providers. A review of hospital inpatient invoices is conducted to validate the utilization Control Agent's approval of admissions and lengths of stay. Treatments and procedures are reviewed to determine if the services are covered by the Program and if the treatments are appropriate for the diagnosis. The Program has developed a computer monitoring system that reviews provider payments, compares providers to their peers and focuses on those providers with exceptional practices. If abuse is suspected, all invoices from the provider are reviewed and medical records are requested and reviewed. If abuse is confirmed, the case is fully developed and administrative action, including recovery of funds and imposition of sanctions, may be taken. Additionally, the case may be referred to the provider's peer review group or to the Board of Physician Quality Assurance. If fraudulent activities are suspected, the provider is referred to the Medicaid Fraud Control Unit in the Attorney General's office for investigation.

RECOVERIES

The Maryland Medical Assistance Program operates a third party liability (TPL) program to discover other sources of payment for Medical Assistance recipients' health care and to recover money spent on behalf of recipients from sources allowed by federal or State law. These sources include health insurance, tort liability (automobile, personal injury settlements, and assault), workers compensation, estates, paternity/child support, provider refunds, recipient fraud, medical malpractice and lead paint poisoning, and the breach of public charge bonds required by the U.S. Immigration and Naturalization Service. The Medical Assistance Program has the responsibility for passing all identified TPL to the MCOs. The Program also imposes liens on the real property of institutionalized people who are determined medically unable to resume living in their community homes, pursuant to the federal Tax Equity and Fiscal Responsibility Act of 1982.

To discover potential third party resources, the Program: collects TPL information of Medical Assistance recipients from Local Departments of Social Services and also conducts data matches with Blue Cross and Blue Shield of Maryland, the Social Security Administration, and the State's Worker's Compensation Commission, Central Payroll, Retirement, and Child Support Enforcement Administration. The Program's third party liability contractor data matches with numerous health insurance carriers. The MCOs enrollment broker collects TPL information which is passed to the Program if the TPL is previously unknown or changed.

THE STATEWIDE EVALUATION AND PLANNING SERVICE

Statewide Evaluation and Planning Services (STEPS) is a preadmission screening program for which Medical Assistance reimburses providers for conducting long-term care evaluations. These comprehensive evaluations are conducted by licensed social workers and registered nurses located in local health departments, and include medical/nursing, psychosocial and functional assessments an appropriate plan of care that is developed with multidisciplinary input. Recommendations might include home and community-based services, which could substitute for nursing home care.

The Program pays for the STEPS evaluation and multidisciplinary assessment for each individual who is determined to be financially and medically eligible. Individuals who are financially eligible are Medical Assistance (MA) recipients or individuals who would be able to establish financial eligibility for MA within six months if admitted to a nursing facility. Individuals who are medically eligible are those who are

certified by the Department or its designee as requiring nursing facility (NF) level of care, or are at risk of needing NF services.

STEPS case management may be provided for MA recipients who have received a STEPS evaluation and for whom case management is recommended in the care plan. STEPS case management is reimbursed at a rate of $90 for initial case management services provided during the 60 days following the assessment, and $15 for ongoing case management provided each succeeding month that case management continues.

PREADMISSION SCREENING AND RESIDENT REVIEW

In January 1989, the State was mandated to implement Preadmission Screening and Annual Resident Review (PASARR) under the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) for individuals with mental illness or mental retardation and related conditions who are applicants to Medicaid certified nursing facilities (preadmission screening) and nursing facility residents (annual resident reviews). In October 1996, the federal regulations were amended to repeal the requirement for annual resident reviews and mandated that resident reviews be conducted when there is a significant change in the resident's mental or physical condition. Evaluations are conducted by Adult Evaluation and Review Services (AERS) teams located in local health departments. The teams are composed of registered licensed nurses, social workers, psychiatrists and psychologists. The AERS teams evaluate whether an individual requires the level of services provided by a nursing facility (NF), and whether specialized services or community services are needed. A plan of care that recommends appropriate services for each individual is developed in a multidisciplinary setting. Upon review of the recommendations, the State Mental Hygiene Administration makes determinations for individuals with mental illness and the State Developmental Disabilities Administration makes determinations of individuals with mental retardation.